Deloitte.

Georgia Pathways Program

Medicaid Capitation Rate Certification Analysis

July 1, 2023 – June 30, 2024

June 12, 2023

Contents

Section 1: Program Overview

In partnership with the Georgia State Department of Community Health ("DCH" or "State"), Deloitte Consulting LLP ("Deloitte" or "We") was engaged to analyze and certify actuarially sound capitation rates for the Georgia Pathways (Pathways) Program for State Fiscal Year (SFY) 2024 (July 1, 2023 – June 30, 2024).

The approach for the Deloitte analysis and rate certification is to develop actuarially sound ranges for various assumptions within the rate development process and certify specific rates that correspond to specific assumptions within the actuarially sound assumption ranges, which is consistent with Section 3.2.1 of Actuarial Standard of Practice #49 (Medicaid Managed Care Capitation Rate Development and Certification):

> "Form of the Capitation Rates (Single Rate or Capitation Rate Ranges)—The capitation rate certification may apply to a single point estimate capitation rate or a range of capitation rates. If a range of capitation rates is prepared, the contracted rates with an MCO may be at either end of the range or a point within the range. The capitation rates may vary by MCO."

The Centers for Medicare & Medicaid Services (CMS) Final rule 42 CFR Section 438.4(b) provides the conditions that must be met for capitation rates to be approved by CMS as actuarially sound and the CMS Final Rule 42 CFR Section 438.4(c) provides the conditions that must be met when developing and certifying actuarially sound rate ranges instead of a point estimate.

DCH has implemented a rate negotiation process that allows contracting care management organizations (CMOs) and their actuaries to review the capitation rate development and provide comments and feedback to DCH. The specific rates submitted by DCH are the result of the negotiation process which is informed by the rate methodology and are then certified by Deloitte actuaries to be actuarially sound if they correspond to specific assumptions that are within the actuarially sound assumption ranges developed by Deloitte.

We are providing the *SFY 2024 Pathways Rate Exhibits.xlsx* document that includes exhibits quantifying the impact of the adjustments and the resulting actuarially sound rates. The rates will be adjusted as necessary to reflect any relevant programmatic changes that were not known at the time of this certification when information is available, if necessary.

Deloitte and the State have developed the capitation rates in accordance with the applicable Centers for Medicare & Medicaid Services provisions under 42 CFR 438 and all applicable Actuarial Standards of Practice (ASOPs). The methods used for calculating these capitation rates are consistent with the requirements of the *2023-2024 Medicaid Managed Care Rate Development Guide* as promulgated by CMS that the capitation rates be actuarially sound and appropriate for the population covered by the program. For purposes of this report, we are defining actuarial soundness consistent with ASOP No. 49, Medicaid Managed Care Capitation Rate Development and Certification. ASOP No. 49 defines that Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates, and other revenue sources provide for all reasonable, appropriate, and attainable costs.

SFY 2024 will be the first year of the Pathways to Coverage (Pathways) program, thus there are no significant changes from prior rate cycles to highlight or a rate comparison to prior certified capitation rates.

To account for the uncertainty inherent in prospective estimates and consistent with ASOP 49, actuarially sound ranges for various assumptions within the rate development were developed. The State selected payable capitation rates that correspond to assumptions within these ranges. Per the *2023-2024 Medicaid Managed Care Rate Development Guide*, this report outlines the certification of these selected capitation rates that will be paid to the participating CMOs.

Program Overview

Pathways provides Medicaid benefits to enrollees in the State of Georgia through a managed care delivery system. The three CMOs are Amerigroup[1], CareSource, and Peach State Health Plan, each currently operating on a statewide basis. The CMOs receive capitation payments from the State for providing health services to the covered populations under the terms and conditions of the managed care contracts.

Georgia received the approval for the 1115 Georgia Pathways to Coverage waiver which authorized the Pathways program on October 15, 2020 and is effective through September 30, 2025. The Pathways program will be implemented on July 1, 2023 during Demonstration Year 3.

The 1115 waiver allows those aged 19-64 up to 100% of the federal poverty line (FPL) to apply for Medicaid coverage in Georgia. Members are required to meet minimum community engagement requirements and reporting requirements or receive good cause exemptions to be eligible and remain in the program.

The Pathways program is eligible for the standard FMAP.

Covered Populations

All individuals who meet the criteria laid out in the CMO Contract are eligible to be enrolled in Pathways. Enrollment in managed care is mandatory for Pathways members.

The information in this report does not cover the Georgia Families (GF) or the Georgia Families 360 (GF360) programs. The rate analyses for these programs will be covered in separate reports.

In the state of Georgia, Pathways Medicaid eligibility criteria are as follows:

- Georgia residents between ages 19 and 64
- Adults with incomes between 35 to 100 percent of the Federal Poverty Level (FPL) who are not currently eligible for Medicaid
- Those who meet the required 80 hours per month of qualifying activities as defined in CMO Contract
- U.S. citizens and qualified immigrants

Covered Services

Pathways enrollees are eligible for the same service benefit package as those enrolled in GF, which include the following covered services:

- Inpatient/outpatient hospital physical health, Inpatient/outpatient hospital behavioral health (MH and/or SUD), Partial hospitalization, Physician, Nurse practitioner, Rural health clinics and FQHCs, Clinic services, Lab and X-Ray
- Prescription drugs, Prosthetic devices, EPSDT, Case management, Family planning
- Dental services (medical/surgical), Dental (preventative or corrective)
- EPSDT benefits for Pathways members who are aged 19-20 only

At a minimum, Medicaid covered individuals are eligible to receive all Medically Necessary Services pursuant to the Georgia State Medicaid Plan. The service category descriptions that capture the covered services described in the CMO Contract for Pathways are detailed more thoroughly in **Section 3** of this report. The capitation rates described in this report include service expenditures specified in **Section 3**. Such Medically Necessary services shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to recipients under Fee-for-Service Medicaid.

[1] Amerigroup is currently undergoing a name change and will be called Elevance Health.

Costs associated with enhanced benefits provided by the CMOs were explicitly excluded from the underlying data used to develop managed care capitation rates. Capitation rates are based only on the cost for services covered as specified under the State Plan or directly related to providing these services.

Institution for Mental Disease

CMOs may cover services provided in an Institution for Mental Disease (IMD) for individuals ages 21-64 for a short-term period not to exceed 15 days per calendar month. CMOs may not require a covered individual to receive services in an IMD if an appropriate alternative setting is available. The member months and any costs incurred in the given month were excluded from the CY 2021 base data for enrollees who exceeded 15 days in an IMD facility for the month(s) in which they exceed 15 days. The claim information was provided by CMOs and was reviewed for appropriateness.

Section 2: Data and Information, Reliance, and Limitations

Data and Information

Various data requests were developed to collect the necessary items to be used for the rate analysis. The State, State's previous actuary, and participating CMOs provided information required for the SFY 2024 capitation rate range analysis. Data and information collected are outlined below.

- Audited Managed Care encounter claims data, including institutional, professional, and pharmacy claims data with dates of service from January 1, 2019 through October 31, 2022, paid through October 31, 2022
- Detailed CMO enrollment and capitation payment data from January 1, 2019 through October 31, 2022, including all applicable retroactive rate cell adjustments through October 31, 2022
- Crosswalks provided by DCH to identify Medicaid eligibility groups, aid categories, categories of service and regions in the encounter/eligibility data
- Monthly detailed CMO Financial Report data by health plan from January 1, 2019 through September 30, 2022; reported data includes detailed expenditures and revenues at the region and rate cell-level consistent with 42 § 438.8 Medical loss ratio (MLR) standards and CMO Contract Section 4.18.2.3.
- Supplemental pharmacy rebate information for CY 2021
- Lists and descriptions of historical, concurrent, and planned changes to the Medicaid programs
- Fiscal estimates and supporting models provided by the State
- SFY 2024 estimated managed care enrollment by cohort and region
- Supplemental quarterly summaries representing non-risk COVID-19 vaccine administration payments to CMOs for the period of January 1, 2021 through June 30, 2022
- Counts and demographic distributions of COVID-19 vaccines administered in Georgia; counts of COVID-19 tests in Georgia by day and DCH Vaccination Data through December 2021
- CMO-specific methodology to identify IMD stays and the number of IMD claims that exceeded the 15-day limit in CY 2021

In addition to the information provided by the State and participating managed care plans, the following items were also considered in the SFY 2024 capitation rate range analysis:

- Publicly available utilization and cost increase studies published by CMS, the SOA, the Kaiser Family Foundation, Magellan, and other state Medicaid programs
- Economic data/indicators from the U.S. Bureau of Labor Statistics (BLS), the U.S. Bureau of Economic Analysis, and the Federal Reserve
- Publicly available State Medicaid Plan and State Plan Amendments for Georgia
- Publicly available studies, reports and information utilized for individual adjustments
- Publicly available data regarding drug patent approvals and expirations occurring or anticipated to occur during the rating period

Appendix C details the publicly available studies that were utilized in the development of the SFY 2024 capitation rates. This section includes all sources that were utilized other than sources provided by the State of Georgia or participating managed care plans. The scope of the capitation rate development and the intended use of the analysis being performed was considered in order to determine the nature of the data needed. Additionally, actuarial standards on utilizing imperfect data

and considering the quality of data were used in the actuarial analysis as outlined in ASOP No. 23, *Data Quality*. The data used in the analysis were determined to be credible unless otherwise noted and are reasonable data sources to develop capitation rates for Pathways services offered to the State of Georgia's Medicaid population.

Reliance and Limitations

In developing the SFY 2024 capitation rates, it was assumed that the CMO contracts for Pathways and all Georgia Medicaid program specifics will be approved by CMS without modifications.

Data provided by the State, State's previous actuary, and participating health plans as detailed above was relied upon. We have reviewed the data for reasonableness and consistency during the course of our work; however, we have not audited any of the data we have received. If the underlying data or information provided is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. Please note that some data sources were provided by third parties who also audited the data provided. We relied on the integrity of the audits performed by these third parties.

This report provides a detailed description of the methodology used in collaboration with DCH to develop the selected capitation rates. The capitation rates have been solely prepared for the State of Georgia and should not be reproduced in any form without the prior consent of Deloitte and should not be relied upon by any entity other than the State of Georgia nor for any other purpose than that expressly stated in this document.

Capitation rates developed by Deloitte and DCH are based on actuarial analysis of future Pathways program costs for SFY 2024. It may be expected that actual experience will vary from the values shown in this report. The methods used for estimating these rates are consistent with CMS requirements detailed in the *2023-2024 Medicaid Managed Care Rate Development Guide* and all applicable actuarial guidance.

Section 3: Rate Analysis Methodology

Overview

This section provides an overview of the rate analysis process used in the development of the actuarially sound capitation rates, including an overview of the rate cohorts, regions, and category of service (COS) groupings utilized in the development of the rates and the adjustments that were applied.

The primary base data sources for the Pathways rate cells that were used in the development of the SFY 2024 Pathways capitation rates were encounter data and enrollment data provided by the State's encounter data auditor and CMO Financial Reports supplied by each CMO. Given that SFY 2024 will be the first year of the Pathways program, there is no historical experience, and the GF Low Income Medicaid (LIM/TM/REF) population was used as a population proxy and relied upon for base data. Please refer to **Section 4** of this report for further detail on the base data.

For Pathways, the following adjustments were applied in the rate analysis process, which are consistent with the *2023-2024 Medicaid Managed Care Rate Development Guide* released in May 2023:

- Base data adjustments
- Population data adjustments
- Program changes not reflected in the base data
- Trend factors to project costs forward to the rating period
- Efficiency adjustments
- Credibility and smoothing
- Non-medical expense loads for administrative costs, underwriting gain, and taxes
- Risk mitigation

The various steps used in the development of the capitation rates are described in the remaining sections of this report.

Population Data Adjustments

The underlying base data for the Pathways program uses data available for the LIM/TM/REF population with adjustments. The LIM/TM/REF cohorts used with the applicable Pathways cohorts are in the table below:

Table 1 - Pathways and LIM/TM/REF Rate Cohorts

LIM/TM/REF Cohort	Pathways Cohort
14-20 Years, Female	19-20 Years, Female
14-20 Years, Male	19-20 Years, Male
21-44 Years, Female	21-44 Years, Female
21-44 Years, Male	21-44 Years, Male
45+ Years, Female	45-64 Years, Female
45+ Years, Male	45-64 Years, Male

Due to program differences, the following additional base data adjustments were made to the proxy data:

- Removal of those under 19 years old from the 14-20 Years rate cells

- Removal of those over 64 years old from the 45-64 Years rate cells
- Removal of experience for those that would be eligible for the LIM/TM/REF program under the pregnancy benefit
    - It is assumed those who become pregnant will transition to the Georgia Families program through the twelve months postpartum period. Experience for those that received a birth kick payment was removed for the 9 months leading up to the birth and the 12 months following.

The impact to the base claim PMPMs are as follows:

Table 2 - Impact of Program Base Data Adjustments

Pathways Cohort	Age Restriction	Pregnant Member Removal
19-20 Years, Female	3.1%	-5.2%
19-20 Years, Male	-23.8%	0.0%
21-44 Years, Female	0.0%	-7.1%
21-44 Years, Male	0.0%	0.0%
45-64 Years, Female	0.0%	0.1%
45-64 Years, Male	0.1%	0.0%

Rate Structure

Based on discussions with the State regarding Deloitte's analysis of cost variation by rate cohort, age, and geographic area within the data, the rate structure for the Pathways rate cells is summarized as follows:

- Six individual cohorts based on member age and gender
- Six regional groupings

Rate Cohorts

For Pathways, separate capitation rates were developed for the following rate cohorts, which are either defined by a combination of age cohort, and gender. **Table 3** below shows each Pathways rate cohort.

Table 3 – SFY 2024 Pathways Capitation Rate Groupings by Cohort

Pathways Rate Cells	Cohort
Pathways	19-20 Years, Female
	19-20 Years, Male
	21-44 Years, Female
	21-44 Years, Male
	45-64 Years, Female
	45-64 Years, Male

Regional Groups

Capitation rates were developed for six regional groupings for Pathways.

The counties that make up the six Pathways rate regions are reflected in **Table 4**. Additionally, **Appendix B** contains a map of the different regions in the State for the Pathways program, as provided by the State.

Table 4 - Region/County Mapping

Region	Counties
Atlanta	Barrow, Bartow, Butts, Carroll, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Haralson, Henry, Jasper, Newton, Paulding, Pickens, Rockdale, Spalding, Walton
Central	Baldwin, Bibb, Bleckley, Chattahoochee, Crawford, Crisp, Dodge, Dooly, Harris, Heard, Houston, Johnson, Jones, Lamar, Laurens, Macon, Marion, Meriwether, Monroe, Muscogee, Peach, Pike, Pulaski, Talbot, Taylor, Telfair, Treutlen, Troup, Twiggs, Upson, Wheeler, Wilcox, Wilkinson
East	Burke, Columbia, Emanuel, Glascock, Greene, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Putnam, Richmond, Taliaferro, Warren, Washington, Wilkes
North	Banks, Catoosa, Chattooga, Clarke, Dade, Dawson, Elbert, Fannin, Floyd, Franklin, Gilmer, Gordon, Habersham, Hall, Hart, Jackson, Lumpkin, Madison, Morgan, Murray, Oconee, Oglethorpe, Polk, Rabun, Stephens, Towns, Union, Walker, White, Whitfield
Southeast (SE)	Appling, Bacon, Brantley, Bryan, Bulloch, Camden, Candler, Charlton, Chatham, Effingham, Evans, Glynn, Jeff Davis, Liberty, Long, McIntosh, Montgomery, Pierce, Screven, Tattnall, Toombs, Ware, Wayne
Southwest (SW)	Atkinson, Baker, Ben Hill, Berrien, Brooks, Calhoun, Clay, Clinch, Coffee, Colquitt, Cook, Decatur, Dougherty, Early, Echols, Grady, Irwin, Lanier, Lee, Lowndes, Miller, Mitchell, Quitman, Randolph, Schley, Seminole, Stewart, Sumter, Terrell, Thomas, Tift, Turner, Webster, Worth

Categories of Service

The base data used for the rate analysis for the Pathways rate cells was organized by the following COS.

Table 5 - Category of Service Descriptions (Pathways Rate Cells)

Category of Service	Description
Inpatient Medical & Surgical	Medical and Surgical costs for routine and ancillary services for members in an inpatient setting.
Inpatient Newborn	Inpatient care costs for newborn enrollees.
Inpatient Mental Health (MH)	Inpatient treatment expenses for mental health and substance abuse stays.
Inpatient Other	Includes all other inpatient services not related to Medical and Surgical, Newborn, or Mental Health.
Outpatient Emergency Room (ER)	Health care procedures, treatments or services provided in a hospital emergency room needed to evaluate or stabilize an emergency situation.
Outpatient Surgery	Outpatient surgery expenses for "same-day" procedures.
Outpatient Radiology	Includes outpatient imaging services.
Outpatient Laboratory	Laboratory expenses on an outpatient basis.
Outpatient MH	Outpatient mental health and substance abuse treatment expenses.
Outpatient Other	Includes all other outpatient services not related to ER, Surgery, Radiology, Laboratory, and Mental Health.
Professional Evaluation & Management (E&M)	Professional service costs associated with diagnosing and treating an illness or injury.
Professional Surgery	Includes professional costs associated with office-based surgeries.
Professional Radiology	Includes physician imaging services.

Category of Service	Description
Professional Lab	Laboratory expenses conducted by a physician.
Professional MH	Professional treatment expenses for mental health and substance abuse.
Professional Ambulance/Transportation	Professional service expenses for Ambulance/Transportation services.
Professional DME/Supplies	Durable medical equipment and other supplies.
Professional Other	Professional service costs not relating to E&M, Surgery, Radiology, Lab, MH, Ambulance/Transportation, or DME/Supplies.
Home Health Care	Home health services including home health aide, therapeutic/private duty/preventive nursing, and medical social services.
Dental	Expenses for dental services provided. Includes all dental services for children up to age 21 and emergency dental services for adults over the age of 21.
Vaccines for Children (VFC)	Costs related to providing vaccines through the federal Vaccines for Children program.
Federally Qualified Health Center (FQHC)	Covered services provided at FQHCs.
Pharmacy	Prescription drugs.
Kick - Facility	Includes facility costs associated with obstetrical delivery events.
Kick - Professional	Includes professional costs associated with obstetrical delivery events.

Services not covered under Pathways

For the SFY 2024 rating period, services not covered under the Pathways benefit package for Pathways enrollees as specified in the CMO Contract are not included. Only State Plan services and 1115 services are included in the SFY 2024 capitation rates.

CMOs have confirmed there are no current or expected in-lieu-of-service arrangements for consideration in SFY 2024 capitation rates.

Impacts of COVID-19 Pandemic

The following impacts of the pandemic and the COVID-19 Public Health Emergency (PHE) and continuous coverage requirement were considered when developing capitation rates for SFY 2024.

- The federal Consolidated Appropriations Act, 2023 enacted December 29, 2022 requires states to resume eligibility redetermination and process all redeterminations by the end of May 2024. The State indicated that disenrollment from Medicaid as a result of the resumption of eligibility redeterminations would be processed on a rolling basis each month through the disenrollment period. For the purposes of developing the capitation rates for SFY 2024, it was assumed that disenrollment would occur uniformly over a 12-month timeframe.

- The impact of the end of the continuous coverage requirement and subsequent unwinding were considered in the development of the administrative, pharmacy, and medical costs. The estimated impact was incorporated through adjustments related to Medicaid churn, acuity changes from the base period through the rating period due to the ongoing maintenance of eligibility requirement and upcoming redeterminations, and in the development of trend. These impacts are described further in **Sections 5 and 6**.

- COVID-19 vaccine administrations are not paid through the capitation rate and are removed from the base data. The base data adjustment is described further in **Section 4**.

Section 4: Base Data Development

The selection and development of base data detailed in this section is consistent with CMS provisions under 42 CFR 438.5(c) and with the guidance detailed in the *2023-2024 Medicaid Managed Care Rate Development Guide*.

Available Data Sources

As described in **Section 2** of this report, two potential data sources were considered: encounter data and CMO-reported financial data. Rates were primarily based on encounter data, which was provided the State's encounter claims audit vendor. CMO reported-financial data was used to support some rate analyses as described throughout this certification. The following table provides a comparison of the two data sources available for medical and pharmacy base data. Both data sources were adjusted to be on the same basis by removing the value-added services and quality improvement activities for the comparison and data was restricted to January 1, 2021 to December 31, 2021 in order to perform a direct comparison of costs below.

Table 6 - Comparison of Available Data Sources

Data Characteristic	CMO Financial Data	Encounter Data
Service Dates Time Period	Monthly data from January 2019 through September 2022	Customizable time periods from 1/1/2019 through 9/30/2022
Payment Runout	Runout through 10/31/2022	Runout through 10/31/2022
Accuracy	Reflects incurred claims and non-claims expenditures as reported by CMO Reports are required to be certified by managed care plans and are evaluated for reasonableness	Less than 1% lower than CMO Financial data for CY 2021 in total for GF
Granularity	Aggregate information split by month, plan, region, and rate cohort	Claim level detail by month, plan, region, rate cohort, and category of service

CMO Financial Report and encounter data were reviewed for year over year differences, overall reasonableness, and consistency between the data sources.

Selected Base Data

The CY 2021 audited managed care encounter data was selected as the primary data source for the medical and pharmacy base data. This data includes detailed, claim-level records, which were then aggregated by COS. Claims were paid through October 2022 which allowed for 10 months of runout from the end of CY 2021.

Data Quality

The State's encounter claims audit vendor was relied upon for all encounter data used for rate setting. We did not audit this data but did perform checks for reasonableness including comparisons with CMO Financial Reports. The CMO-reported MLR data and financial data were also reviewed for accuracy and completeness.

The state has a high level of confidence in the CMO encounter data based on the third-party ongoing review to validate the monthly invoice files against the CMO check registers. However, there are still slight discrepancies between the total PMPM costs reported in the CMO encounter data and CMO-reported financial data. The **Under Reporting** section details the adjustments made to account for the difference in costs between these two sources.

Based on our data review and validation for the data completeness, accuracy, and consistency, the data used to develop the SFY 2024 capitation rates was found to be of appropriate quality and suitable for developing actuarially sound rates. FFS data was not utilized or provided for this analysis.

Base Data Adjustments

As historic data was not available for the Pathways population, the existing capitation methodology and data for the GF program was used as the primary source of the base data and base data adjustments. All data sources are consistent with the data used to develop the GF SFY 2024 rates.

The base data was reviewed to validate that the expenses reflect the population and services included in the GF benefit package. Through this process, the following adjustments were considered and applied to the underlying base data. The below base data adjustments are applicable to the proxy base data that was used to develop the Pathways capitation rates.

Base Data Adjustments to Encounter Data:

Removed from Base Data

- Incarcerated Member Exclusion
- Capitated Encounters
- Value-Added Services
- Pharmacy Rebates
- Under 19 and over 64 years of age
- Pregnancy benefit period of 9 months prior to birth and 12 months post-partum

Added to Base Data

- Non-System Payments
- Sub-Capitated Payments
- Incurred But Not Reported (IBNR)
- Under Reporting

The impact of each adjustment at a regional, rate cohort, and category of service level are provided in Exhibits Section A in the accompanying "SFY 2024 Pathways Rate Exhibits.xlsx" file.

Incarcerated Member Exclusion

The incarcerated member exclusion excludes the costs and member months for Medicaid enrollees while incarcerated. Incarcerated members are identified through the individual member's capitation data.

Non-Risk COVID-19 Vaccine Exclusion

The COVID-19 vaccine administration costs were removed from the pharmacy encounter base data as the CMOs are not at risk for these costs. The CMOs are reimbursed for the administration of the COVID-19 vaccines outside of the capitation rates. The COVID-19 vaccine claims were identified using NDC.

Capitated Encounters

Some of the CMOs have sub-capitated arrangements for portions of the State Plan-approved benefit package with subcontractors, referred to as sub-capitated providers. The encounter claims submitted for these sub-capitated services do not reflect the actual CMO expenses incurred to provide these services as the CMOs pay these sub-capitated providers through separate sub-capitation payments. Therefore, these capitated encounters are removed from the base data and as discussed below, are

replaced with the actual payments CMOs make to their sub-capitated providers to reflect the actual costs incurred by the CMOs. Capitated encounters are identified using the capitated vendor list provided by the State's encounter claims audit vendor.

Value-Added Services

The CMO-reported costs for value-added services from the CY 2021 plan financial data were removed from the base data. CMOs reported value-added services on a statewide and category of aid-specific basis and encounter data for related categories of service was leveraged to remove the value-added services costs by rate cell.

Pharmacy Rebates

An adjustment was made to the pharmacy component of the rate to account for rebates retained by plans participating in Pathways. These rebates are not reflected in the encounter data used as the base pharmacy data, and therefore, the base pharmacy costs would be overstated without this adjustment.

The CMOs provided historical and estimated rebate information at the rate cell level from CY 2019 through the third quarter of CY 2022 in the plan-submitted financial data. CY 2021 reported rebates were analyzed to develop a downward adjustment applied to the pharmacy base data. CY 2021 rebate information was compared to CY 2019 through Q3 CY 2022 rebate information to validate the reasonableness of the data provided by the plans and the magnitude of the applied adjustment.

Age Restriction

Pathways eligibility is restricted to individuals who are 19-64 years of age. The base data used to develop the Pathways capitation rates leveraged the experience for LIM/TM/REF members aged 14 and up, and experience was removed for those outside of the Pathways eligible age range. Both costs and member months were excluded.

Pregnancy Exclusion

Pregnant members with an income at or below 220 percent of the FPL are eligible for GF. Individuals who become pregnant while enrolled in Pathways will transition to the GF program during their pregnancy continuing into 12-months postpartum coverage, and all related pregnancy, delivery, and postpartum costs are expected to occur in the GF program. The estimated prenatal and 12-month postpartum period for members who had a delivery diagnosis code were removed from base data used to develop Pathways capitation rates. Both costs and member months were excluded.

Non-System Payments

Non-system payments made to providers that were not otherwise included in the encounter base data that reflect covered expenses for the CMOs were added to the CY 2021 base data. CMOs reported their non-system payment amounts at the statewide and major category of service level; these values were allocated across rate cells and appropriate service categories using base encounter data for related categories of service, consistent with the SFY 2023 rate development. Any non-system claims payments reported for administrative, non-State plan services, or medical management services were not added to the base data. The non-system payments were reviewed for reasonableness and consistency over the data periods provided (CY 2019 through Q3 CY 2022) but relied on the CMOs for reporting accuracy.

Sub-Capitated Payments

The base data has been adjusted to include plan-reported expenditures for sub-capitated covered provided in the CMO financial data. Sub-capitated payments were reported at the statewide level and by major category of aid. Sub-capitated payment costs were allocated to rate cells proportionally by member month for the given category of aid for applicable categories of service.

Incurred But Not Reported (IBNR)

The CMOs reported their IBNR values by rate cell and major category of service in the plan financial data. The CMO-reported IBNR estimates were reviewed by individual CMO and across the program.

After analyzing the available IBNR data, an adjustment by category of aid and major category of service was applied to the CY 2021 base data using the plan reported IBNR amounts to adjust base data to include the estimated IBNR amounts.

Under Reporting

The CY 2021 encounter data was adjusted to align with the costs reported in the plan-reported financial data for the pharmacy and medical data. To determine the variance between the encounter pharmacy data and CMO Financial Report pharmacy data, the two data sources were adjusted so they were comparable for the purposes of this analysis. To do this, the encounter data was adjusted to remove value-added service claims and the quality improvement activities as reported from the CMO financials.

After normalizing the data sources to be on a comparable basis, it was observed that the encounter data varied from the CMO Financial Report data by category of aid. Adjustments were made to reconcile the encounter data to the CMO Financial Report audited financial data.

Section 5: Program Change Adjustments

Explicit adjustments were made to account for the Pathways programmatic changes between the base data period and the rating period. This is consistent with applicable actuarial guidance regarding the rate setting methodology. Programmatic changes occurring during the base period data were applied before trend. Programmatic changes, including new benefits, with effective dates after the base period were applied after trend.

Program change adjustments were made for the medical and pharmacy components of the rate separately. The program change adjustments are categorized as follows and the adjustments were applied in the following order for medical and pharmacy separately:

- Pre-trend benefit adjustments
- Post-trend adjustments

Table 7 - Program Change Adjustments

DCH Program Change	Category	Effective Date	Medical/Pharmacy
Increase to Dental Fee Schedules	Pre-Trend	7/1/2021	Medical
Increase to Primary Care and OB/GYN Fee Schedules	Pre-Trend	7/1/2021	Medical
15-Day Institutions for Mental Disease Exclusion	Pre-Trend	N/A	Medical and Pharmacy
Increase to Dental Fee Schedules	Post-Trend	7/1/2022	Medical
Independent Pharmacies Dispensing Fee Increase	Post-Trend	7/1/2022	Pharmacy
Medical Nutritional Therapy	Post-Trend	7/1/2022	Medical
Long-Term Acute Care/Inpatient Rehabilitation Facilities Increase	Post-Trend	7/1/2022	Medical
Psychiatric and Behavioral Healthcare Management	Post-Trend	7/1/2022	Medical
Leap Year	Post-Trend	N/A	Medical and Pharmacy
Redetermination Acuity Adjustment	Post-Trend	7/1/2023	Medical and Pharmacy
Churn	Post-Trend	7/1/2023	Medical and Pharmacy
Psychiatric Residential Treatment Facilities (PRTF) Reimbursement Increase	Post-Trend	7/1/2023	Medical
Developmental and Behavioral Health Screening and Testing	Post-Trend	7/1/2023	Medical
Smoothing	Post-Trend	N/A	Medical and Pharmacy
Pent-Up Demand	Post-Trend	7/1/2023	Medical and Pharmacy
Pathways Acuity	Post-Trend	7/1/2023	Medical and Pharmacy

The below adjustments are applicable to the Pathways program only, unless otherwise specified. Exhibit 3 in the *SFY 2024 Pathways Rate Exhibits.xlsx* file highlights the impact of the program change adjustments.

The following program changes applicable to the GF population were deemed immaterial or not applicable to the Pathways population:

- Increase to OB/GYN Fee Schedules – Maternity expenditures have been removed from the proxy base data used for Pathways rate development, thus the OB/GYN fee schedule increase is not applicable.
- Donor Milk Program – the donor milk benefit is applicable to those under 1 year of age and is not applicable to the Pathways population.
- Applied Behavioral Analysis (ABA) – The observed growth from the base period to the contract period for ABA services is impacting primarily children. While ABA experience for 19+ was not removed from the base data, no additional adjustment for ABA utilization was included in the Pathways rate development process.
- Behavioral Health Aide – Similarly to ABA utilization, Behavioral Health Aide services are expected to impact primarily children. No adjustment for Behavioral Health Aide services was included in the Pathways rate development process.
- Extended Postpartum Coverage – Maternity benefit eligible women will be covered under the GF program rather than pathways.

Pre-Trend Benefit Adjustments

This section details the benefit adjustments between the base period and the rating period. As these adjustments have effective dates during the base period, they were applied before trend.

Increase to Dental Fee Schedules

Effective July 1, 2022, a 3% increase was applied to the reimbursement for following dental procedure codes: D2140, D2150, D2160, D2330, D2331, D2332, D2335, D2393, D2394, D2930, D2931, D3220, D7111, D7140, and D7210.

Paid and utilization data for the affected dental procedure codes from January 1, 2021 through June 30, 2021 was summarized by category of aid, cohort, and region. The increase in cost by rate cell was estimated by multiplying the utilization by procedure code by the increase in the associated fee schedule.

Increase to Primary Care and OB/GYN Fee Schedules

Effective July 1, 2021 the reimbursement rate for 18 procedure codes increased from the 2014 Medicare rates to the 2020 Medicare rates for all physicians. The relevant procedure codes are 90472, 99230, 99204, 99212, 99213, 99214, 99215, 99223, 99232 99233, 99284, 99285, 99391, 99392, 99393, 99394, and 99480.

Paid and utilization data for the 18 procedure codes from January 1, 2021 through June 30, 2021 was summarized by category of aid, cohort, and region. The increase in cost by rate cell was estimated by multiplying the utilization by procedure code by the increase in the associated fee schedule.

15-Day Institutions for Mental Disease (IMD) Exclusion

The IMD exclusion prohibits the use of federal funding for care provided to most patients in IMD facilities larger than 16 beds. The exclusion is applicable to all Medicaid enrollees under the age of 65, except for payments for inpatient psychiatric services provided to beneficiaries under age 21. IMD stays greater than 15 days were identified in the CY 2021 base period using plan reported IMD data and the claims and member months were removed from the base data for the Medicaid beneficiaries exceeding 15 days in an IMD facility for the month(s) in which they exceed 15 days.

Post-Trend Benefit Adjustments

This section details the benefit changes between the base period and the rating period. As these adjustments have effective dates after the base period, they were applied after trend.

Increase to Dental Fee Schedules

Effective July 1, 2022, the reimbursement for two dental extraction codes was increased 10% and the reimbursement for 17 dental restorative codes was increased 7%. The 10% increase applies to dental codes D7140 and D7210. The 7% increase applies to dental codes D2160, D2330, D2331, D2332, D2335, D2393, D2394, D2931, D3220, D7111, D2140, D2150, D2930, D0220, D0270, D0272, and D0274.

Paid and utilization data for the affected dental procedure codes from January 1, 2021 through December 31, 2021 was summarized by category of aid, cohort, and region. The increase in cost by rate cell was estimated by multiplying the utilization by procedure code by the increase in the associated fee schedule. The percent impact of the fee schedule increase was applied to estimated SFY 2024 dental costs.

Independent Pharmacies Dispensing Fee Increase

Effective July 1, 2022, the State increased the dispensing fees for medications dispensed at independent pharmacies for recipients enrolled in a Medicaid managed care plan to $10.63 per prescription.

DCH provided a list of independent pharmacies, including provider identification codes. The dispensing fees, prescription count, and paid data for drugs dispensed at independent pharmacies where script count, dispensing fee quantity, and paid amount was greater than zero were summarized from January 1, 2021 through December 31, 2021 by rate cell using the provider identification codes. The percent impact to the pharmacy category of service by rate cell was estimated by repricing the dispensing fees at $10.63 and the percent impact was applied to projected SFY 2024 pharmacy costs.

Medical Nutrition Therapy (MNT) Reimbursement

Effective July 1, 2022, the unit cost paid for MNT procedure codes 97802 (Medical Nutrition Assessment) and 97803 (Medical Nutrition Re-assessment) were increased for the Fee-for-Service (FFS) Medicaid program and DCH indicated that the managed care program would have the same percent increases as the FFS increases. Also effective July 1, 2022, procedure code 97804 (Medical Nutrition Group Therapy) was added as a covered service.

The State provided a fiscal estimate of the cost of incorporating the MNT program changes into the managed care program for SFY 2023. Paid amounts, utilization, and unique utilizer counts were summarized for procedure codes 97802 and 97803 from January 1, 2021 through December 31, 2021 by rate cell. The SFY 2023 fiscal estimate was validated for reasonability and split out by category of service based on the underlying categories of service to which the CY 2021 data was allocated (Professional – Other, FQHC, and Outpatient – Other), trended forward to SFY 2024, and allocated out by rate cell using the distribution of the MNT utilizers.

Long-Term Acute Care Hospitals & Inpatient Rehabilitation Facilities Increase

Effective July 1, 2022, the per diem reimbursement rate increased by 10% for long-term acute care hospitals (LTAC) and inpatient rehabilitation facilities (IRF). The State provided a list of the relevant facilities and Provider Specialty Codes. Inpatient paid and utilization data from January 1, 2021 through December 31, 2021 was summarized by facility, rate cell, and category of service in combination with the Provider Specialty Codes. A 10% increase in cost was applied to estimate the impact of this program change adjustment. The percent impact of the reimbursement increase was applied to the projected SFY 2024 for the IP – Medical & Surgical and IP – Other categories of service.

Psychiatric and Behavioral Healthcare Management

Effective July 1, 2022, Case Management Services were expanded using procedure codes, 99446, 99447, 99448, and 99449, 99484, 99492, 99493, and 99494. The State provided an SFY 2023 fiscal estimate of the costs of adding these new Case Management procedure codes and indicated that members who are already using case management codes will not have additional utilization of the new codes and that utilization will be limited to patients who have received Community Mental Health services.

Unique utilizer counts were summarized from January 1, 2021 through December 31, 2021 of members who have not utilized case management services and who have received Community Mental Health. The SFY 2023 fiscal estimate was validated for reasonability, trended forward to SFY 2024 and allocated out to non-maternity rate cells according to the distribution of these utilizer pulls.

Leap Year

The upcoming rating period of July 1, 2023 through June 30, 2024 has 366 days due to the "leap" day on February 29, 2024. Conversely, the selected base period of January 1, 2021 through December 31, 2021 has 365 days. An adjustment was applied to all categories of service to increase the costs paid in the rating period to cover this additional day of service.

Redetermination Acuity Adjustment

Effective March 1, 2020, a PHE was declared. Under the Maintenance of Effort requirements, members that would typically be disqualified for Medicaid were allowed to remain in Medicaid programs. As part of the Consolidated Appropriations Act, 2023, the State is required to return to normal eligibility and enrollment operations which includes redetermining eligibility for members who are enrolled in Medicaid under Maintenance of Effort requirements but no longer qualify for Medicaid benefits. The State indicated that disenrollment from Medicaid as a result of the resumption of eligibility redeterminations would be processed on a rolling basis each month through the disenrollment period. For the purposes of developing the redetermination acuity adjustment, it was assumed that disenrollment would occur uniformly over a 12-month timeframe.

Using the most recent CDPS+Rx cost weights and risk score assignments based on CY 2019 and CY 2021 scoring periods, the average risk score changes were analyzed to understand how the acuity of the population changed due to the impact of the MOE requirement. From the analysis, lower levels of acuity were observed across the LIM/TM/REF program as a result of the continuous coverage requirement. The observed decline in population acuity from CY 2019 to CY 2021 was assumed to continue beyond CY 2021 until redeterminations occur. As redeterminations occur, acuity is expected to begin to return to pre-PHE levels due to the end of the continuous coverage requirement. The redetermination adjustment estimates the expected change in acuity, measured by risk score, and corresponding PMPM cost changes as members are redetermined on a monthly basis throughout SFY 2024.

Churn

The federal Consolidated Appropriations Act, 2023 enacted December 29, 2022 requires states to resume eligibility redetermination and process all redeterminations by the end of May 2024. The State indicated that disenrollment from Medicaid as a result of the resumption of eligibility redeterminations would be processed on a rolling basis each month through the disenrollment period. As eligibility redeterminations are processed, the impact of Medicaid beneficiaries losing coverage and subsequently re-enrolling in the program within a short period of time will likely occur. This phenomenon is often referred to as "Medicaid Churn". As a result of the continuous coverage requirement that existed during the PHE, Medicaid Churn rates were estimated to be minimal during the CY 2021 base period. Because there is expected to be a difference in the rates of Medicaid Churn between the base period and the rating period, an adjustment was required to address this phenomenon.

To estimate the impact of Medicaid Churn during the rating period, an estimate was developed for reduced capitation payments and member months due to Medicaid churn in the rating period that will not be accompanied by a proportional reduction in claim costs since churning members are assumed to be healthier than average. This assumption was developed using the expected leavers from Medicaid due to the end of the continuous coverage requirement throughout SFY 2024, leavers from Medicaid due to steady state churn throughout SFY 2024, historical joiners and leavers from the Medicaid program observed from CY 2019 to the first 9 months of CY 2022 and national studies on the rates of churn prior to the public health emergency.

Psychiatric Residential Treatment Facilities (PRTF) Reimbursement Increase

Effective July 1, 2023, the reimbursement at PRTF sites of service is increased to 75% of the Medicare Inpatient – Rehabilitation rate.

Paid and utilization data at PRTF sites of service from January 1, 2021 through December 31, 2021 was summarized by category of aid, cohort, and region. The increase in cost by rate cell was estimated by multiplying the utilization by the increase in the reimbursement rate. The percent impact was applied to projected SFY 2024 medical costs.

Developmental and Behavioral Health Screening and Testing

Effective July 1, 2023, the reimbursement for behavioral screening and testing codes will increase to the 2021 Medicare equivalent rate. The increase applies to procedure codes 96112 and 96113. Paid and utilization data for the affected procedure codes from January 1, 2021 through December 31, 2021 was summarized by category of aid, cohort, and region. The increase in cost by rate cell was estimated by multiplying the utilization by procedure code by the increase in the associated fee schedule. The percent impact of the fee schedule increase was applied to projected SFY 2024 medical costs.

Smoothing

A smoothing adjustment was applied to each region such that the statewide age/gender PMPM relativities were maintained across rate cells while preserving budget neutrality. This adjustment is applied using post-trend PMPMs for all Pathways rate cells.

Pent-Up Demand

A temporary increase in utilization is expected during the implementation phase of Pathways due to pent-up demand for individuals who previously had limited access to service. Individuals who were previously not eligible for State or Medicaid-sponsored benefits will likely have higher service utilization compared to the proxy population used for Pathways rate development due to pent-up demand. An adjustment was included in the Pathways rate development process to account for this expected pent-up demand. This adjustment relied upon historical GF data and assessed durational data for new members to estimate increased utilization.

Effective March 1, 2020, a Public Health Emergency (PHE) was declared. Under the Maintenance of Effort requirements, members that would typically be disqualified for Medicaid were allowed to remain in the Medicaid programs. As part of the Consolidated Appropriations Act, 2023, the State is required to return to normal eligibility and enrollment operations which includes redetermining members who are enrolled in Medicaid under Maintenance of Effort requirements but no longer qualify for Medicaid benefits. The State indicated that disenrollment from GF and P4HB as a result of the resumption of eligibility redeterminations would be processed on a rolling basis each month through the disenrollment period. For the purposes of developing the capitation rates for SFY 2024, it was assumed that disenrollment would occur uniformly over a 12-month timeframe. It is expected that a portion of the members that will be disenrolled from the existing GF program will be eligible for Pathways and will transition into the Pathways program after their application is approved without a gap in coverage. Given the anticipated seamless transition, these members have been excluded from the Pent-up Demand Analysis.

Data for the proxy population was summarized by month and PMPM costs were compared for members enrolled for 0-11 months to members enrolled more than 12 months. The adjustment was calculated separately for members who are currently in the GF program and will be transitioned into Pathways and those expected to be newly enrolled into Medicaid. Estimated Pathways membership for individuals who were not previously eligible for State or Medicaid-sponsored benefits as a portion of total estimated Pathways membership was used to blend these factors and develop an overall increase of 1.18% which was applied to all Pathways rate cells.

Pathways Acuity

Using publicly available research from The Kaiser Family Foundation and AcademyHealth in partnership with the Disability Consortium, Deloitte expects that members in the Pathways population will have a lower medical acuity when compared to the GF population that was used as the proxy base data for Pathways rate development. An analysis was conducted to determine the differences in acuity between the members in the base data who are expected to remain in the GF program and members who would be disenrolled from GF but eligible for Pathways. Cost and risk score data was used to compare differences between the two populations, and an adjustment factor was developed based on the relativities. Estimated Pathways membership for individuals who are currently enrolled in GF as a portion of the total estimated Pathways membership was used to develop an overall reduction of 1.11% which was applied to all Pathways rate cells.

Section 6: Trend

The trend estimates the increase in overall expenditures of providing health care services from the base period to the rating period. For the Pathways program, estimated GF trends were leveraged.

Medical

When developing the medical trend estimates, the following data sources were analyzed:

- Encounter data from January 2019 – October 2022
- CMO Financial Report data from January 2019 – September 2022
- CMO reported trends for CY 2019 – CY 2022
- Industry trends including Medicaid-specific CMS National Health Expenditures, Medicaid-specific Kaiser Family Foundation, other State Medicaid trends and the Consumer Price Index for medical services

The GF experience as reported in the CMO Financial Report data and encounter data was used as the primary data sources to analyze trend because they represent the specific populations and services that are covered under Georgia's Medicaid program. Due to expected population changes occurring between the historical data available at the time of developing the SFY 2024 capitation rates and the contract period, it was necessary to apply an acuity adjustment to the historical experience to isolate the change in trend. Additionally, an IBNR adjustment was applied to the data to remove cost and utilization shifts attributable to runout.

After accounting for these adjustments, PMPM trends, which are comprised of both utilization and unit cost trends, were analyzed by time period (monthly, quarterly, annually), COS, cohort, and region to develop a range of trend rates.

In addition to the CMO Financial Report and encounter data, industry trends from a variety of sources were considered, as specified above. Both actual and observed trends for recent years were reviewed.

The trends selected in the rate development are summarized in **Table 8**.

The following table details the range of annual PMPM trends by major COS; total PMPM trends displayed will vary by rate cell based on service mix These trends were selected by considering the trend sources discussed above. Consideration was also given to emerging trends in 2022 for COVID-19, program and reimbursement changes arising from State budget changes, and changes in the acuity of the population between the base period and the rating period. The impact of the end of the continuous coverage requirement and subsequent unwinding is captured in a separate adjustment outside of trend.

Table 8 – Category of Service Annual PMPM Trends – Pathways

Major COS	Low Estimate Trend	High Estimate Trend
Inpatient	1.7%	2.7%
Inpatient Mental Health	5.0%	7.8%
Outpatient Emergency Room	5.3%	8.3%
Outpatient Mental Health	1.4%	2.3%
Outpatient	5.7%	8.9%
Professional Mental Health	7.1%	11.0%
Professional Evaluation & Management	4.3%	6.7%

Major COS	Low Estimate Trend	High Estimate Trend
Professional	3.0%	4.7%
Home Health	0.7%	1.1%
Dental	2.1%	3.3%
FQHC	1.4%	2.3%
TOTAL	**3.6%**	**5.7%**

Trend rates were also analyzed in aggregate with all categories of service, regions, and cohorts combined. The following range of aggregate PMPM trends were observed within each source, comparing multiple time periods. These observed trends are comparable to the selected PMPM trend aggregated from the selected COS trends in **Table 9** below.

Table 9 – Observed Annualized Aggregate PMPM Medical Trends Range

Data Source	Time Period	Duration of Analysis	Annualized PMPM Trend
CMO Financial Report	CY 2019 – 3rd quarter of CY 2022	Annual	-9.8% to 11.3%
Encounter	CY 2019 – October 2022	Annual	-10.8% to 7.0%
Industry[2]	CY 2018 – CY 2023 (Proj.)	Various	-0.2% to 7.1%

Unit cost and utilization trends were analyzed separately in addition to PMPM trends. Ultimately the trend selections were not based on the separate unit cost and utilization trends as significant volatility was observed over the time periods and across categories of service. The observed PMPM trends provided a better representation of expected future experience and were ultimately used as a contributing source to the ultimate trend selection.

For medical services, trend was applied from the midpoint of the base period to the midpoint of the rating period as shown in **Table 10** below.

Table 10 – Medical Trend Months

Base Period	Rating Period	Trend Months
January 1, 2021 – December 31, 2021	July 1, 2023 – June 30, 2024	30

The range of non-pharmacy trend assumptions along with the selected non-pharmacy assumption, developed by category of service, region, and cohort are shown in Exhibits 1 and 4 in the accompanying *SFY 2024 Pathways Rate Exhibits.xlsx* file.

Pharmacy

Pharmacy trends were developed in a similar manner as medical trends. A variety of sources were analyzed including:

- Encounter data from January 2019 – October 2022
- CMO Financial Report data from January 2019 – June 2022
- Industry trends including Magellan, Medicaid CMS National Health Expenditures and other State Medicaid trends

[2] Includes trends from Medicaid-specific CMS National Health Expenditures, Medicaid-specific Kaiser Family Foundation, and the Consumer Price Index for medical services

For the GF experience as reported in the CMO-reported financial data and encounter data, the data was adjusted for IBNR and normalized across years to reflect changes in the acuity of the population from January 2019 through October 2022. These adjustments are applied to compare the data across different periods and remove shifts in cost and utilization attributable to runout and acuity due to the continuous coverage requirement. After accounting for these adjustments, utilization, unit cost, and overall PMPM trends were analyzed under multiple time periods, levels of detail (i.e., COS, cohort, region), and averaging methods. This analysis enabled consideration of the range of trend rates to consider and included annual, monthly, and quarterly trends.

Trend rates were analyzed by therapeutic class, regions, and cohorts. The therapeutic class trends were analyzed utilizing the encounter data experience. For each therapeutic class, high-cost drugs, drugs with expiring patents and a change in the primary drugs being utilized in each therapeutic class were analyzed and considered when developing therapeutic class trend rates.

Industry trends were also reviewed at a therapeutic class level from a variety of sources as specified above.

The following table summarizes the range of annual trends by therapeutic class. These trends were selected by considering the trend sources discussed above.

Table 11 – Therapeutic Class Annual PMPM Trends

Therapeutic Class	Low Estimate Trend	High Estimate Trend
Antiasthmatic and Bronchodilator	2.6%	3.8%
Analgesics – Anti-Inflammatory	9.0%	12.9%
Dermatological	13.3%	18.8%
ADHD/Anti-Narcolepsy/Anti-Obesity/Anorexiants	-1.8%	-2.7%
Antidiabetics	1.4%	2.0%
Antivirals	2.7%	3.9%
Endocrine and Metabolic	2.4%	3.4%
Antineoplastics and Adjunctive Therapies	0.8%	1.2%
Respiratory Agents	11.2%	15.8%
Antipsychotics/Antimanic	10.6%	15.1%
Other	3.1%	4.4%
TOTAL	**4.8%**	**6.9%**

Trend rates were also analyzed in aggregate for all regions and cohorts. The following range of aggregate PMPM trends were observed within each source, comparing multiple time periods. These observed trends are comparable to the Selected PMPM trend aggregated from the selected therapeutic class trends in the table above.

Table 12 – Observed Aggregate PMPM Pharmacy Trends

Data Source	Time Period	Duration of Analysis	Annualized PMPM Trends
CMO Financial Report	CY 2019 – 3rd Quarter of CY 2022	Annual	0.4% to 14.5%
Encounter	CY 2019 – October 2022	Annual	3.8% to 22.7%
Industry	CY 2018 – CY 2023	Various	1.5% to 7.3%

PMPM trend rates were reviewed by cohort and region to consider adjustments for observed differences across cohorts or regions; based on this review, the cohort and region-specific trends did not warrant further modification to the selected trend.

Ultimately the trend selections were not based on the separate unit cost and utilization trends as significant volatility was observed over the time periods and across categories of service. The observed PMPM trends provided a better representation of expected future experience and were ultimately used as a contributing source to the ultimate trend selection.

Pharmacy trend was applied from the midpoint of the base data to the midpoint of the rating period as shown in below.

Table 13 – Pharmacy Trend Months

Base Period	Rating Period	Trend Months
January 1, 2019 – December 31, 2019	July 1, 2023 – June 30, 2024	30

The range of pharmacy trend assumptions, along with the selected pharmacy assumption, developed by region and cohort are shown in Exhibits 1 and 4 in the accompanying *SFY 2024 Pathways Rate Exhibits.xlsx* file.

Section 7: Managed Care Savings Adjustment

Adjustments were made to account for improved efficiencies anticipated to be reasonably attainable by CMOs in Georgia.

Managed Care Savings Adjustment

Pathways

Even though the contract period is the initial year of the Pathways program, it is expected that CMOs will be able to achieve reasonably attainable efficiencies by the end of the contract period.

This adjustment is based on observed efficiency opportunities by comparing each CMO acuity adjusted experience by rate cohort and region to the combined experience.

To calculate the adjustment, an efficiency ratio was calculated for each CMO within each rate cell by comparing their actual acuity adjusted CY 2021 cost to the weighted average of the acuity adjusted CY 2021 cost across CMOs for the given rate cell. The acuity adjusted actual PMPM cost for each CMO for each rate cohort and region was calculated by dividing their actual unadjusted base CY 2021 cost by the corresponding CY 2021 risk score. CY 2021 risk scores are based upon:

- Historical, State-specific cost weights consistent with the CDPS+Rx risk adjustment methodology
- CY 2021 Member-level diagnostic and claims information
- CY 2021 Enrollment

Note that CY 2021 data was used as it was the most recent complete year of risk score information available during the development of the managed care savings adjustment.

Efficiency ratios with a value greater than 1.0 indicated potential inefficiency relative to the average and ratios with a value of less than 1.0 indicated greater than average efficiency. For each ratio greater than 1.0, actuarial judgement was used to develop what reasonably attainable improvements in efficiency during the contract period. The efficiency ratios that were less than or equal to 1.0 were not modified. A weighted average efficiency adjustment was then developed for each rate cell.

The GF adjustment was calculated as a percentage decrease to the Pathways-comparable rate cells. The Pathways managed care savings adjustment leveraged the GF calculation and was then reduced by 50% to account for additional expected costs the CMO may incur to manage the Pathways program during the implementation phase.

Given the expected continuous coverage for members who are expected to transition from GF to Pathways, the Managed Care Savings adjustment was applied to this portion of members for the entire contract period.

For the remaining members who were not previously eligible for State or Medicaid-Sponsored benefits, a ramp-up factor was applied by month anticipating that the CMOs will be able to continue to improve efficiency throughout the rating period for the new Pathways members.

The final adjustment of -0.33% was applied to all Pathways rate cells.

The impact of the efficiency adjustment was developed for each rate cell as detailed in Exhibits 1 and 4 in the accompanying "SFY 2024 Pathways Rate Exhibits.xlsx" file.

Section 8: Non-Medical and Case Management Expenses

This section summarizes the estimated non-medical and case management expenses included in the capitation rates. Non-medical expenses include administrative expenses, underwriting gain, and premium-based taxes. For the Pathways program, estimated GF administrative costs were leveraged for both variable and fixed admin costs.

Administrative Expenses

To develop the administrative expenses included in the SFY 2024 capitation rates, CY 2021 administrative expense data reported in the CMO Financial Reports was analyzed. The CMO Financial Report administrative expense data was reviewed for reasonableness. It was assumed that administrative cost data will vary by category of aid, so the administrative cost development was developed separately for the following major categories of aid. The Pathways program utilizes the administrative costs from the LIM/TM/REF category of aid.

Based on a review of the expenses reported, the CY 2021 experience was allocated into fixed and variable components. The allocated administrative fixed costs in dollars and variable administrative costs per enrollee were trended forward to the rating period. The administrative expense trends were selected based on historical and emerging CMO Financial Report experience and publicly available data sources including Georgia Consumer Price Index information published by the U.S. Bureau of Labor Statistics, the U.S. Bureau of Economic Analysis, and the Federal Reserve.

When estimating the fixed administrative expense PMPM, the impact of the end of the continuous coverage requirement and subsequent unwinding was considered as estimated enrollment is utilized in the calculation. The federal Consolidated Appropriations Act, 2023 enacted December 29, 2022 requires states to resume eligibility redetermination and process all redeterminations by the end of May 2024. The State indicated that disenrollment from Medicaid as a result of the resumption of eligibility redeterminations would be processed on a rolling basis each month through the disenrollment period.

Additionally, administrative expenses were added to account for several of the program changes highlighted in **Section 5** that are related to services that will have additional administrative impacts. Admin adjustments were applied for the following program change adjustments: Medical Nutritional Therapy, Psychiatric and Behavioral Healthcare Management, and Leap Year.

As the administrative expense base data includes pharmacy pass-through costs, the administrative expense load includes a provision for estimated SFY 2024 pharmacy pass-through costs.

The range of administrative expense assumptions, as well as the selected administrative expense assumptions, are displayed in Exhibit 4 in the *SFY 2024 Pathways Rate Exhibits.xlsx* file.

Underwriting Gain

The selected capitation rates include a provision for underwriting gain of 1.25% across all regions and cohorts. The provision for underwriting gain covers the minimum cost of capital and margin for risk of participating health plans under reasonably attainable assumptions and is consistent with similar programs and insurance products in other states and marketplaces.

The underwriting gain assumptions are shown in Exhibit 1in the *SFY 2024 Pathways Rate Exhibits.xlsx* file.

Premium-Based Taxes

The selected capitation rates include a provision for premium-based taxes of 2.25% across all regions and cohorts as Georgia requires that all health insurance companies pay a state premium tax of 2.25%. The premium-based taxes assumptions are shown in Exhibit 1in the *SFY 2024 Pathways Rate Exhibits.xlsx* file.

Section 9: Risk Mitigation

The State uses several mechanisms to mitigate risks within the Pathways program. The mechanisms described below are applied after the development of the actuarially sound rates.

Minimum Medical Loss Ratio

For the Pathways program, the State has set a Minimum Medical Loss Ratio (Minimum MLR or MMLR) percentage at 86% in compliance with Georgia HB 1013 which requires a minimum MLR of at least 85% starting July 1, 2023 (SFY 2024).

The methodology to calculate the MLR is outlined in the contract and in accordance with the standards outlined in 42 CFR §438.8. The MLR formula is calculated as (Incurred Claims + QIA) / (Reported Premium – Taxes & Fees). As a note, QIA refers to costs associated with quality improvement activities. Directed payments will be included in the SFY 2024 MLR calculation as incurred claims in the numerator and as reported premium in the denominator.

The PCK pricing MLR is 86.8%. Including QIA, the anticipated MLR under this minimum MLR formula is 87.1%.

The State reimbursement for the Pathways minimum MLR will be calculated based on the below ranges.

Table *14* – MLR Reimbursement

MLR	CMO Gain/Loss Share	State Gain/Loss Share
< 86%	0%	100%
≥ 86%	100%	0%

The State will implement a remittance for plans whose MLR is below the minimum MLR threshold based on the difference between the plan's actual MLR and the minimum MLR.

Risk Adjustment

Risk adjustment will not be applied to the Pathways program in SFY 2024.

Section 10: Delivery System and Provider Payment Initiatives

The State does not have any current or expected Delivery System or Provider Payment Initiatives that impact the Pathways program.

Section 11: Capitation Rate Submission

An actuarially sound ranges of assumptions were developed to account for uncertainty inherent in components of the capitation rate analyses. Each of the estimated benefit and non-benefit expense data sources and adjustments was reviewed and discussed with the State to understand levels of reasonableness and potential material uncertainty. Through this analysis, actuarially sound low-estimates and high-estimates for the trend and administrative expenses were developed based on additional sensitivity analyses of rate components to account for potential volatility. Each of these estimates was calibrated to account for volatility in the underlying data and potential differences in prospective assumptions. The low-estimates and high-estimates for these assumptions are shown in Exhibits 1 and 4 for Pathways in the *SFY 2024 Pathways Rate Exhibits.xlsx* file.

The resulting rate components were reviewed with the State, and the State selected the payable capitation rates for the Pathways program in SFY 2024 that correspond to specific assumptions within the actuarially sound ranges. Exhibit 1 in the *SFY 2024 Pathways Rate Exhibits.xlsx* file also show the capitation rates submitted by the State, which are certified by Deloitte actuaries to be actuarially sound. Exhibit 5 provides a comparison to the GF LIM/TM/REF SFY 2024 rates. As Pathways is a new program previous SFY 2023 rates for the program are not available.

The rates will be adjusted as necessary to reflect any material programmatic changes that occur during the rate period.

Section 12: Actuarial Certification

I, Steve Wander, am a Principal with Deloitte Consulting LLP (Deloitte). I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. I meet the Academy's qualification standards for rendering this opinion.

I, Tim FitzPatrick, am a Principal with Deloitte Consulting LLP (Deloitte). I am an Associate of the Society of Actuaries and a Member of the American Academy of Actuaries. I meet the Academy's qualification standards for rendering this opinion.

The Georgia State Department of Community Health (DCH) retained Deloitte to assist in the development of the Georgia Pathways (Pathways) rate development methodology, assumptions and resulting capitation rates, as well as to provide the actuarial certification required under the Centers for Medicare & Medicaid Services requirements 42 CFR 438 for the period of July 1, 2023 to June 30, 2024, for the Pathways program.

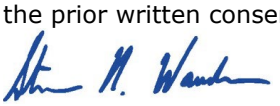
We certify that the Pathways program rates are actuarially sound and satisfy the following:

- The capitation rates have been developed in accordance with applicable actuarial standards of practice.
- The capitation rates are appropriate for the Medicaid populations to be covered, and Medicaid services to be furnished under the managed care contract.
- The capitation rates meet the applicable requirements of 42 CFR 438; and
- The capitation rates submitted by DCH are based on assumptions that are within the Pathways programs' actuarially sound assumption ranges developed by Deloitte, respectively.

In this capitation rate analysis for the period of July 1, 2023, to June 30, 2024, we have relied on historical claims and enrollment experience data and program information provided to us by DCH as outlined in the Data and Information, Reliance, and Limitations section. We have reviewed the data for reasonableness and consistency during the course of our work; however, we have not audited any of the data we have received. If the underlying data or information provided is inaccurate or incomplete, the results of our review may likewise be inaccurate or incomplete.

Capitation rates analyzed and assumption ranges developed by Deloitte are based on actuarial analysis of future Pathways program costs for the effective period of July 1, 2023, to June 30, 2024. It may be expected that actual experience will vary from the values shown here. Deloitte has developed these rates to demonstrate compliance with the applicable CMS provisions under 42 CFR 438.

This document is solely for the information and use of the Georgia State Department of Community Health and is not for the benefit of or to be relied upon by any other person or entity. This document may not be disclosed to anyone outside the Georgia State Department of Community Health without the prior written consent of Deloitte.



Steve Wander, FSA, MAAA

Deloitte Consulting LLP

Tim FitzPatrick, ASA, MAAA

Deloitte Consulting LLP

Appendix A: Rate Exhibits

Please refer to the accompanying file *SFY 2024 Pathways Rate Exhibits.xlsx* for exhibits documenting the detailed build-up of the SFY 2024 rates as referenced throughout this memorandum.

Appendix B: Regional Map

Appendix C: Outside Data Sources

The below list details information utilized in the development of the SFY 2024 capitation rates that was not provided by Georgia State or participating managed care plans.

- *2022 Milliman Medical Index,* Milliman, Inc. https://us.milliman.com/en/insight/2022-milliman-medical-index
- *CPI-All Urban Consumers U.S. Medical Care*, United States Department of Labor, Bureau of Labor Statistics. https://data.bls.gov/cgi-bin/surveymost?cu
- https://www.federalreserve.gov/monetarypolicy/fomcprojtabl20221214.htm
- *Medical Cost Trends: Behind the Numbers 2022, PWC. https://www.pwc.com/us/en/industries/health-industries/library/behind-the-numbers.html*
- *National Health Expenditure Data,* Centers for Medicare and Medicaid Services*. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData*
- *Medicaid Enrollment & Spending Growth: FY 2022 & 2023,* Henry J Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-spending-growth-fy-2022-2023/
- *Medical Pharmacy Trend Report,* Magellan Rx Management. Medical Pharmacy Trend Report 2022 by Magellan Rx Management - Issuu
- *Minimum Wage,* New York State Department of Labor. https://www.labor.ny.gov/workerprotection/laborstandards/workprot/minwage.shtm
- *Total Medicaid Expenditures*, Statistica. Medicaid expenditure total U.S. 1966-2019 | Statista
- *2022 Health Care Cost Model*, SOA. https://www.soa.org/resources/research-reports/2021/covid-19-cost-model/
- *2021 Medicare Physician Fee Schedule Changes*, CMS. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched
- Other State Medicaid Managed Care Actuarial Certifications
- *Medicaid Enrollment Churn and Implications for Continuous Coverage Policies,* KFF. *https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/*
- *An Updated Look at Rates of Churn and Continuous Coverage in Medicaid and CHIP,* MACPAC. *https://www.macpac.gov/publication/an-updated-look-at-rates-of-churn-and-continuous-coverage-in-medicaid-and-chip-abstract/*
- *Rates of Medicaid Churn and Continuous Coverage Among Children and Working-Age Adults with Disability-Related Eligibility, Mathematica.* https://www.mathematica.org/publications/rates-of-medicaid-churn-and-continuous-coverage-among-children-and-working-age-adults
- *Understanding the Intersection of Medicaid & Work: A Look at What the Data Say* https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-work-a-look-at-what-the-data-say/
- *The Relationship Between Work and Health: Findings from a Literature Review* https://www.kff.org/medicaid/issue-brief/the-relationship-between-work-and-health-findings-from-a-literature-review/
- *Advancing Health Justice Using Medicaid Data: Key Lessons from Minnesota for the Nation* https://www.healthmanagement.com/wp-content/uploads/advancinghealthjusticeusingmedicaiddata_jan2021_0.pdf